RE-ORIENTATION OF MEDICAL EDUCATION SCHEME

(ROME SCHEME)

GUIDELINES FOR IMPLEMENTATION

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AND

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MEDICAL COLLEGE
KOTTAYAM
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PREFACE

ROME Scheme has been in operation in the Medical Colleges of kerala since 1979 but the implementattion was tardy and the progress uneven. There has not been a concerted effort to implement the scheme in an efficient and uniform manner.

The guidelines presented here for the uniform implamentation in Kerala State is the direct outcome of a decision of the State level meeting of the principals and Co_ordinators of ROME Scheme held in the Office of the Director of Medical Education on 27–5–88, entrusting the responsibility to me, Much effort has been put in the preparation of the guidelines, in perusing the relevant state Government Orders, Govt of India directions, Medical Council of India suggestions and decisions of the three Regional Consultative Committee meetings on ROME Seheme organised by the Regional Office of the W. H. O, New Delhi. Close laison also has been kept with the Co–ordinators of ROME Scheme of all Medical Colleges of Kerala in getting relevant information and valuable comment s which were given due consideration.

I sincerely hope that the guidelines would help the concerned faculty members of all Medical colleges to improve upon the efforts already had taken in the proper implementation of ROME Scheme. Finally let me thank Mr. P K Natarajan, Assoc. Professor of Health Educatio(NC), Rome Scheme, who had been fully involed with me in the preparation of the guidelines.

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GUIDELINES FOR IMPLEMENTING RE-ROEINTATION OF MEDICAL EDUCATION SCHEME IN KERALA

Introduction

The medical education of modern medicine started in India with the starting of the first Medical School in Calcutta in 1822 followed by the Medical colleges in Madras and Calcutta in 1835. Gradually more Medical Colleges came into existence in our major cities and towns. From the beginning the teaching was hospital based and urban oriented and the vast majority of doctors who were graduated from the above Medical Colleges had confined their service activities within major cities and towns. The major chunk of the population, who were living in villages were neglected and denied the services of modern medicine and had to be satisfied with the existing Indian systems of medicine. The state of affairs continued even after forty years of our independance and in spite of having 106 Medical Colleges admitting 12,000 students every year. All the census reports and special surveys conducted by Planning Commission after independance. have brought out the naked fact that twothirds of the doctors of modern medicine are still serving only the people living in urban areas who constitute only 20% of the population.

How the national minimum health needs of the people in villages be met? Here Comes the relevance of change in the existing medical education system. The objective of any system of medical education would be to generate man power equipped to serve the real health needs and demands of the population. In this process the education system must involve itself in bringing about the desired change in the health delivery system

To achieve the above, the Ministry of Health and Family Welfare, Govt. of India appointed a top level committee called 'The Group on Medical Education and Support Manpower' and the report of the said Group (Srivastava committee report) was submitted to the Govt in 1974. The recommendations of the Group were duly processed by a sub-committee to the Ministry and a concrete plan of action was drawn up. This was adopted by the third joint meeting of the Central Council of Health & Family Planning and were later on ratified by the conference of Deans and Principals of Medical Colleges in India in 1976. Govt. of India consider it of paramount importance that implementation of part 'C' of the plan of action, namely involvement of Medical Colleges in Community health problems and re-orientation of Medical Education should be undertaken with celerity and promptiude by each of the concerned State/Union territories on time bound priority so that the much aspired social objectives underlying it could be achieved.

Consequently the Govt. of India launched the Re-orientation of Medical Education Scheme in theyear 1977. Govt. of kerala examined the proposal of the Govt. of India in consultation with the Principals of the Medical colleges and the Director of Health Services and implemented the scheme in to to as per G. O. (MS) No. 281/79/HD dt. 14-12-79 of Health (p) Department.

Overall objective of the scheme

Involvement of the Medical Colleges in the commuity health problems and in direct delivery of health care services to the rural population.

Specific objectives.

a. Exposing the students to the rural environment.

b. Exposing the faculty members of the Medical Colleges to the rural environment.

c. Upgrading the quality of health services in rural and peripheral areas with provisions of expertise and assistance in specialised servlces such as laboratory services, radiology services, etc.

d. Taking responsibility of promotive, preventive, rehabilitative and curative health care of 3 Community Development Blocks in the beginning and later on in the District within 3–5 years.

GUIDELINES SET FOR THE IMPLEMENTATION OF THE SCHEME BY THE GOVERNMENT OF INDIA

ROME_I - Guide

To facilitate to achieve the above objectives the Govt. of India formulated a set of guidelines to evole a viable and pragmatic shape to the implementation process of this scheme in the various Medical Colleges. It is necessary that every endeavour should be made to consistently adhere to these guidelines both in spirit and content so that the implementative proeess gains momentum uniformly in the Medical Colleges in the desired manner and directions. The guidelines detailed below was approved by the planning Commission as well as the Finance division of the Health and Family welfare Ministry, Govt. of India.

1. The Govt Medical College will take up the total responsibility of promotive, preventive and curative health care of 3 C. D Blocks in the beginning and later on in the entire district within 3–5 years.

2. Each Medical College will evolve with the active involvement of the Dist. Hospitals, Taluk & primary Health Centres a well–knit referral service complex. To achieve this, a working group will be set up at the Medical Colleges or Civil Hospitals under the Chairmanship of the Principal/Dy. Director of the region involving personnel from these institutions.

For the success of such referral system, a continous dialogue will be maintained between the institutions involved. To start with a programme will be chalked out involving the centres which are nearer to the Medical Colleges, The staff of the Medical College will be required to attend the District and Taluk Hospital by rotation for the purpose of improving the hospital services. The Medical college will also extend co-operation in providing the peripheral units mainly in the expertise and assistance in laboratory service, radiology services, clinical services implementation of national programmes, control of communicable diseases' nutrition, maternal and child health services and familyplanning. With this aim in view the resources of the Medical Colleges, District and Taluk hospitals and Primary Health Centre will be pooled together, in respect of man power, transportation equipment, contingent grants, etc. to evolve a well-knit referral system.

3. For the proper training of the undergraduate students in the rural health care programme, it is necessary that a balance is struck between the training he receives in the Medical College, District hospital and P. H. Centres.

4. Suitable time table to be worked out by the Medical Collages for posting of the undergraduate students to District, Taluk and subdivision level hospitals and P. H. Centres. Duration of this posting should not be less than 8weeks, rural posting of the interns at all thesee levels for at least 6 months.

5. For the successful implementation of the total health care and improved. training programme for the undergraduate students, it is imperative that entire faculty members, clinical paraclinical and non-clinical are involved in this programme The staff members from the entire faculty will be posted at primary health centres and sub-centres by rotation for sufficiently long a period where they will be respo-nsible for guiding the training of unbergraduate students as well as interns and will supervise the development and implementation of the entire health care delivery programmes. It will also be necessary to organise a re-orientation programme for faculty members and health team personel af each Medical College.

6. Services of the personel at District hospital level, subdivisional hospital/Taluk hospital level or P. H. C. level should be utilised for organising the training programme of the undergraduates. This will ensure closer co-ordination and comradeship between Medical College faculties and peripheral staff.

7. The entire period of internship training will be spent in suitably upgraded district hospital, taluk/subdivisional hospitals and P. H. centres. Depending upon the availability to facilities at District hospitals, the no.of interns posted at the Medical College hospitals will be reduced.

8. The Medical College staff will extend their services to be fullest extent in the training of para-medical and other ancilliary health staff, required in the developement of a three–tier system of delivery of health care.

9. It is essential to collect the baseline data about the health status of the community concerned so that in future the impact of the entry of the Medical College in the health care delivery system could be evaluated periodically. The information will be collected in the following areas: demographic data, family planning, maternal and child health, nutritional status, communicable diseases especially TB. leprosy and V. D. parasitic infestations, etc.

10. Each Medical College will evolve a scheme for health care delivery system in depth for a population of about 30,000. The experience gained from these experimental models will be utilised in extending in depth services for the rest of the area in future.

11. At present the research that is being carried out in Medical Colleges is individual based and of limited application to the needs ot the community. Therefore, the Medical Colleges will formulate research schemes which will have practical application to the basic health needs of the community.

12 In order to motivate the students in their whole hearted participation in the rural posting a scheme of periodical assessment of the studies will be built in the programme. At the university level, the examination will be so structured that a stress will be laid on the assessment of knowledge gained by the students during the posting.

13. To bring about the far reaching changes in the present system of medical education/health care delivery system, an effective administrative machinery will be evolved for co–ordinated effects and for providing official support for the field programme. Constitution of committees at the institutional, regional and state level should be done with the composition broadly as follows:–

a. Institutional level committee has to be constituted by the Dean and will preferably include senior staff members whose involvement is necessary for the success of the programme. It may also invite relative health department officials to attend the meeting.

b. At each Medical College level there will be regional coordination committees with District Collector as the Chairman, Principal, Medical College and Dist. Medical Officer as members and Prof. of Community Medicine ~~or Medicine~~ as member secretary.

c. The State level Co-ordination Committee will consist of:

1. Minister of Public Health (Chairman)

2. Minister of Harijan Welfare (Vice-chairman)

3. Secretary (Health), Member

4. Secretary (Development), Member

5. Director of Health Services, Member

& 6. Director of Medical Education, Member Secretary.

d. The Re-orientation of Medical Education is a 50:50 centrally sponsored scheme but the onus of implementation of this scheme rests on the State Government concerned, health being a State subject.

e. The salient features of the schemehave been embodied in the recommendations of the Medical Council of India on undergraduate medical curriculum—adopted by the M. C. I. at its meeting held on 19-3-1981. The council recognises the importance of the community aspects of health care and or rural health care services. This aspect of the training of undergraduates has been adequately recognised in the prescribed curriculum throughout all the three phases of the training. This has been further emphasised and intensified by providing on the job instruction and training during the internship period.

The amendment to incorporate the salient features of 'ROME' Scheme in the undergraduate curriculum by the Medical Council of India implies that implementation of the scheme is now mandatory and as such the defaulting Medical College stands the risk of derecognition by the council.

f. Central assistance: Under the revised pattern of Phase I of the 'ROME' Scheme the centre is providing Rupees Four lakhs each to selected P. H. Centres for construction of Dormitory type residential accommodation for students (10 male students and 5 female students and 5 faculty members' a seminarroom-cum-lecture room,

operation theatre and other additions. Rs. 75,000/— was allotted for the procurement of a mini bus and Rs. 30,000/— each for the construction of garage for each of the Mobile Clinics.

ROLE OF WHO IN THE IMPLEMENTATION OF ROME SCHEME

A WHO Global study in 1975 has indicated that at least two—thirds of the rural population of the world have no access to any form of professional health care. This has moved several countries to search for alternative strategies for providing health care, strategies that will result in the development of primary health care, and has culminated in the declaration made at the Alma Ata Conference, whose objective is to achieve "Health for All by the year 2000" ie. attainment of a level of health by all citizens of the world that will permit them to lead a socially and economisally productive life. Primary health care was identified as 'the key' to attain the social target of health for all. The declaration of Alma Ata defined primary health care as"... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination". The eight basic elements coming under primary health care are:

1. Education concerning prevailing health problems and the methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition.
3. An adequate supply of safe water and proper sanitation.
4. Maternal and child health care including family planning.
5. Immunisation against the major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases and injuries; and
8. Provision of essential drugs.

The social goal of health for all through primary health care brought the issues of relevance of medical education into sharper focus and posed challenges to medical colleges to respond adequately to the changing social needs. The World Health Organi—zation, during the last decade, has provided leadership and support to the movement of Reorientation of Medical Education in a number of different ways.

In order to enhance awareness among decision makers, share knowledge and experiences and monitor the progress being made the South East Asia Regional Office of the W. H. O. organized a series of regional consultations on Re–orientation of Medical Education.

The first was the inter country meeting on "Re–orientation of Medical Education towards community needs" (ROME I) held in Surabaya, Indonesia, in June, 1979. This meeting standardized the terminology being employed in relation to 'ROME', identified the primary roles of a medical graduate in the context of primary health care and emphasized the need for systematic, competency based curriculum development.

The second consultative meeting on ROME was held in the Regional Office, New Delhi during October 1983. This meeting developed a comprehensive strategy for re–orienting medical education as a total responsive system.

The third meeting of the intercountry consultative committee was held from 12–2–1987 to 20—2—1987 in the W. H. O. Regional Office, New Delhi. The meeting recommended a scheme for monitoring and evaluating the implementation of programmes, facilities for reorientation of medical education at country and regional levels.

EVALUATION & ASSESSMENT OF ROME 'SCHEME'

So far 105 Medical Colleges and the post–graduate Institute, Chandigarh have accepted the scheme. It has been felt that the implementation of the scheme has not been upto the required expectation. The Government of India, Ministry of Health & Family Welfare in 1981 had set up an evaluation team to methodically assess and evaluate the implementation of 'ROME' Scheme, with Dr. D. B. Bisht, the then Additional Director General of Health Services as the Head of the team. His report included the following points:–

I. 1. Taluk or District Hospitals have not been involved by most of the Medical Colleges in training and providing primary health care.

2. The committees set up in the State, Regional and Institutional levels are not meeting frequently.

3. Involvement of faculty members other than P.S.M Department is not satisfactory.

4. Due to lack of funds and administrative procedures, construction work is not progressing as desired.

5. Referral system established between the periphery and other levels is not highly satisfactory.

6. Mobile Clinics are underutilised due to shortage of medical and paramedical staff, lack of supporting transport facilities to carry the staff and students, inadequate funds for fuel and technical difficulties in taking these vehicles to interior villages.

II. In January 1981, a British team visited Medical Colleges in 5 States and 2 Union Territories to evaluate the operation of the Mobile Clinics. They recommended for the provision of vehicle to each Medical College to transport staff and students, construction of permanent garage for the vehicles and appointment of Co—ordinator for each State for the proper implementation of 'ROME' Scheme.

III A national workshop on 'ROME' Scheme was held in Vigyan Bhavan, New Delhi from 28th to 31st August, 1985 for Co-ordinators of all the 106 Medical Colleges, for Principals/Deans of all Medical colleges from 30th to 31st August 1985 with the Co—ordinators and a followup meeting of Health Secretaries of State/ Union Territories and Directors of Medical Education was held on 27th and 28th of September 1985.

The Co-ordinators and Principals reviewed the present functioning of the 'ROME' Scheme in the participating institutions, identified the problems encountered and suggested remedial measures for better operation of the scheme. The follow-up meeting of Secretaries and Directors of Medical Education considered, the outcome of the previous meetings and made necessary recommendations for the healthy implementation of 'ROME' Scheme. Following were the final recommendations.

(a) The Head of the institution will be responsible for implementation of 'ROME' Scheme. All Heads of Departments of the Institutions will be fully involved in it. The Head of the Institute will identify a senior staff member from among the faculty of the Institute who will be designated as the Co-ordinator of 'ROME' Scheme and he will asaist the Head of the Institution in the implementation of 'ROME' Scheme.

Government of India may immediately assist the States in organising brief orientation course for all the staff in each of the Medical Colleges to acquaint them with the main features of 'ROME' Scheme and identify their role and responsibility in the operation of the scheme.

(b) It was recommended that P. H. Centres attached to Medical Colleg s should be under the control of the Medical Colleges as far as possible. It is expected that the new arrangements will help in achieving the objectives of the health care delivery system in the District according to practices and conditions prevalent in different States, in addition to effectively carrying forward the implementation of 'ROME' Scheme.

(c) All the private Medical Collegee under the purview of 'ROME' Scheme should be treated at par with the Govt. Medical Colleges and all facilities and assistance should be provided equally.

(d) Accommodation and other construction works under the 'ROME' Scheme should be expedited and suitable facilities should be provided within the specific time schedule so that the staff and students be immediately posted for the recommended period of stay at the Primary Health Centres,

Government of India may provide additional grant wherever the cost of construction has escalated provided the construction has alredy been undertaken by States/Union Territories.

(e) If was felt that as the Mobile Vanscan not always go to the periphery because of lack of proper road facilities. it is necessary that 3 Mini buses/Jeeps be given to each Institute to facilitate students and faculty members transpor tand movement within the P. H C. system Maintenance facili'ies for all the vehicles should be available in the institute itself. Suitable funds should also be provided for these vehicles to perform their tasks. Spare parts for the imported vehicles may be procuted and provided by the Government of India.

(f) The staff recommended by the Medical Council of India for various Depa tments should be appointed immediateiy. It was also recommended that for 'ROME 'Scheme, the following separate staff should be provided.

a. 3 Lecturers/Asst. Professors (under 'ROME' scheme)

b. 1 Asst.Field Co–ordinator of the rank of Associate Professor/Reader (ROME Scheme)

c. 1 Lecturer/Asst. Professor of the rank of Asst. Professor in Anthrapology/ Sociology.

The State Committee will decide the placement and qualification of staff Appro–priate teaching designation may be given to the staff of the Dist Health Office and of the P. H Centres who are involvedin the 'ROME' Scheme.

(g) There should be preparation of educational material for the 'ROME' Scheme at the national level which should be distributed to all the Medical Colleges.

(h) The Co–ordination Committee at College level should meet three monthly, at Regional level – sixmonthly, State and at National level – yearly.

(i) Monitoring of the programme should be done by each institution and they should submit a report to the State authorities as well as to the central authorities quarterly and the evaluation of the entire scheme at the institute and state level should be done by an independant agency from time to time. Concurrent evaluation of the activities can be done by the respective institutes for their own feedback.

Monitoring machinery should be suitably strengthened.

(j) It was recommended that the students performance in the 'ROME' Scheme should be suitably assessed in the University Examination and due credit should be given for the performance of the assessment at the University level. Medical council of India should conduct regular inspection of Medical Colleges to locate deficiencies and defects, if any, in the implementation of 'ROME' Scheme and also will take suitable remedial measures.

(k) Each P. H. Centre should be connected with the Institute by telephone or any other communication system. Medical records and other statistical information should be maintained regularly by each P. H. Centre as well as in the institution. Additional staff should be provided for this.

(l) There should be enough flexibility and openness built into the scheme to suit the needs of each individual institute / community.

(m) There should be continuing education, built in research and teaching of appropriate health education in the scheme.

(n) There should be adequate central assistance for the proper implementation of the scheme.

IMPLEMENTATION OF THE SCHEME IN KERALA

Though the 'ROME' Scheme started in 1977, in many Medical Colleges in India, Govt. of Kerala issued orders of sanction of the said scheme in Kerala only in 1979 as per G. O. (MS) No.281/79/HD dt. 14–12–1979. The introduction of 3 Mobile Clinics each in the 4 participating Medical Colleges of Kerala in 1980 was the real beginning of the implementation of the scheme.

An evaluation on the functioning of 'ROME' Scheme was first carried out by the Accountant General of Kerala in 1983 According to his report the progress was tardy, expenditure incurred on many items were irregular and specific activities were not initiated. The civil construction works envisaged under the scheme hava not been either taken up or completed. No research project have been taken up by the Medical Colleges as contemplated in the programme. The faculty of the Medical Colleges had not visited the District and Taluk hospitals to improve and involve in primary health care and national health programmes. Subsequent state level meetings and special meetings organised by the Director of Medical Education and the Health Secretary in 1984 and 1985 also expressed their dissatisfaction over the unsatisfactory performance of the scheme.

The State level co-ordination committee meeting held on 26-4-1984 noted that the different Medical Colleges were trying to implement the scheme in their own way and that there was no overall plan for the successful implementation of the scheme in our State. The Committee wanted to formulate a basic plan applicable to all Medical Colleges of the State and suitable to the prevailing conditions. It was decided that a Committee consisting of the Professors in charge of the programme in each of the 4 Medical Colleges may be entrusted the responsibility to formulate the basic plan immediately.

The task of preparing the guidelines for the uniform inplementation of the scheme in all Medical Colleges was entrusted to Dr. K. P. Poulose, Professor of Medicine, Medical College, Kottayam by the Director of Medical Education during the meetnig of the Principals and Co-ordinators of 'ROME' Scheme held on 27-5-1988 at the Directorate of Medical Education, Trivandrum. To start the work in earnest, a brief report on the functioning of 'ROME' Scheme in each Medical College was requested and obtained.

An objective analysis of the available report of the 4 Medical Colleges clearly show that even now we have not been able to implement all the 13 major guidelines suggested by the Govt. of India, satisfactorily. We were not able to make much headway in the orientation of staff members and students to the new approach of training and health care. While partial implementation of some of the guidelines are attempted, many items are not being given any importance and hence the programme could not make any noticeable impact.

SUGGESTED GUIDELINES TO IMPLEMENT 'ROME' SCHEME IN THE MEDICAL COLLEGES OF KERALA

Being the most literate State among the 25 States of the Indian Union and having the highest health status and health infrastructure facilities it is our duty to be the torch bearer of change and to implement the new medical education policy of the Government of India in totality, adhering to the suggested 13 guidelines both in spirit and content. We should not be complacent with the existing enviable health status of our State but should take every endeavour to bring our level of health on par with any developed country in all aspects, as early as possible.

The task analysis of the suggested 13 guidelines would give us a clear understanding of the activities to be carried out by each Medical College to implement the scheme so as to aehieve the general and specific objectives of the scheme satisfactorily. The same is attempted in the following chart in which major activities to be carried out and responsibilities against each guideline are indicated. The Institutional level committee of each Medical College in our State is expected to make an assessment of the present level of implementation of the scheme in terms of the desired activities to be carried out and to make appropriate modifications in the ongoing programme.

GUIDELINE No. I	ACTIVITIES TO BE CARRIED OUT (TASKS TO BE PERFORMED	RESPONSIBILITY
The Govt. Medical College will take up the total responsibility of preventive, promotive and curative health care of 3 Community Development Blocks in the begi—nning and later on in the entire district within 3–5 years.	The Head of the Institution should	State Govt. already issued Govt. Order (G. O. MS. No. 281/79/HD/ dtd. 14-12–1979)
	1. Get technical control of 3 P. H Centres of the C. D. Blocks.	
	2. Conduct Regional Committee meeting to involve Health Services staff.	Co—ordinator.
	3. Assess health care needs of the people living in the P· H. C. area (3) through survey and analysis.	P H.C. & Medical College staff and students including interns.
	4 Assess the available resources and facilities men, money and materials.	do.
	5. Prepare a plan of action-short term & long term.	do.
	6. Implement the plan making it time bound.	do.
	7. Evaluate the performance periodically.	do.
	8. Expand the scheme to the entire District.	do.

GUIDELINE No. II		
Each Medical College will evolve with the active involvement of the Dist. & Taluk Hospitals and P. H. Centres a well–knit referral service complex.	1. Decide to evolve a well–knit referral complex, comprising the 3 P.H. Centres and neighbouring Taluk and District hospitals, in the institutional and regional committee meetings, set—up	Principal, Medical College, D. M. O., Co-ordinator, 'ROME, Scheme.

	a small working group with the Principal as Chairman and Medical Officers in charge of the various Institutions as members. Carry outperiodicalmeetings of this working group to assess the referral systems' success and difficulties, and to find out ways of improvement referral service.	
2.	Assess health care facilities in each of the 3 levels and design criteria for referring eses from each institution.	Senior faculty members of the Medical College & senior Medical Officers of District & Taluk Hospitals and P.H Centres.
3.	Improve health care facilities in each institution.	Principal, Medical Officers in charge and Co–ordinator.
4.	Arrange visits of senior faculty members to the District and Taluk hospitals & P. H. Centres.	Principal & Co—ordinator.
5.	Provide assistance in laboratory and radiology services clinical services and in the implementation of national health programmes.	Principal, Co—ordinator, Heads of all Departments.
6.	Pool resources in the 3 levels–manpower, transport, equipment etc. for opitmum utilisation.	Principal, Heads of Depts., Medical Officers i/c of Institutions.

GUIDELINE No. III		
For the proper training of the undergraduate students in the rural health care programme, it is necessary that a balance is struck between the training he receives in the Medical College, Dist. Hospitals and P.H.Centres.	1. Set up an expert committee to go into the problem and suggest practical solution.	Central Government (Indian Medical Council had already given recommendation for the same in 1981.)
	2. Decide on the period to be utilised for training of undergraduates in District and Taluk hospitals and P. H. Cs.	Institutional Committee & Co-ordinator.
	3. Decide on the content of training and faculty to be involved from Medical College and Health Services in the training.	Institutional Committee and Dist. Medical Officer.

GUIDELINE No. IV	ACTIVITIES	RESPONSIBILITY
Suitable time-table to be worked out by the Medical Colleges for the posting of the undergraduate students to District, Taluk & PHCs. Duration of posting should not be less than 8 weeks. Rural posting of the interns at all these levels for at least 6 months as recommended by I.M.C.	1. Arrange at least 15 field visits for the students in the pre—clinical period, spreadover 18 months, in various aspects of Community Medicine as recommended by M..C.I.	Dept. of Community, Medicine
	2. Shift the centre of training of community posting of 2nd clinical years from the Medical College to the PHC (seminar hall of the 'ROME' Scheme building).	do. & Co—ordinator, 'ROME' Scheme.
	3. Take necessary steps to get 30 full working days for the above posting and frame detailed programme as given on page 39 of M.C.I. recommendation on graduate medical education. Prepare a time table for the same.	Institutional Committe, Dept. of Com. Medicine and Co-ordinator, 'ROME' scheme.

	4. Involve the teachers of the Medical College faculty in rotation, in family health survey, discussion on data presentation, health education and provision of primary health care.	do.
	5. Conduct the training of each batch under the supervision of a teacher from the Medical College faculty who will be given residential posting in the 'ROME' Scheme building.	All Depts. of Medical College
	6. Involve the P.H.C. Medical officers and the staff in the training of the students.	Co-ordinator
	7. Involve interns posted in the PHC actively in the conduct of the programme.	Co-ordinator& Dept. of Com. Medicine.

GUIDELINE No. IV	ACTIVITIES	RESPONSIBILITY
Interns' training programme:	1. Take necessary steps to enhance rural posting in District, Taluk & PHCs to 6 months as recommended by I. M. C.	Regional Committee, Institutional Committee & Co-ordinator.
	2. Plan, organise and conduct training of interns in administrative, preventive and clinical aspects as detailed from page 40 to 43 on the "IMC recommendations on Graduate Medical Education".	Institutional Committee, Co-ordinator and Com. Medicine Department.
	3. Conduct periodic evaluation of the training and find out ways of improvement.	do.

GUIDELINE No. V

For the successful implementation of the total health care and improve training programme of the undergraduate students it is imperative that the entire faculty members, clinical, paraclinical and non–clinical are involved in this programme. The staff members from the entire faculty is posted at PHCs and subcentres by rotation for sufficieatly long a period. They will guide the training of undergraduates and interns & supervise the development and implementation of the entire health delivery system.	1. Organise training programme for faculty members and health team personnel of the College for favourable attitudinal change and effective involvement. 2. Fix roles and responsibilities to each Dept. in the training of undergraduates and interns and in the primary health care services in the district. 3. Prepare a plan of action of posting faculty members from all departments to District and Taluk hospitals and P.H. Centres.	Expert from Govt. of India Principal & Co–ordinator Principal and all heads of Departments. Principal & Co – ordinator & Heads of Depts. & Heads of Institutions.

GUIDELINE No. V (contd.)	ACTIVITIES TO BE CARRIED OUT	RESPONSIBILITY
Organise re_orientation programme for faculty members and health team personnel of the college & the senior doctors and staff of the District	1. Decide a plan of action in the institutional level committee. 2. Implement and evaluate. 3. Supply relevant guidelines and background materials.	Central Agencies, Principal, Co–ordinator, Prof. of Com. Medicine.

GUIDELINE No. VI

Service of the personnel at Dist. Hospital, Taluk & P. H. C. level should be utilised for organising the training programme of the undergraduates. This will ensure closer co-ordination and comradeship between medical college faculties and peripheral staff.	1. Take appropriate decision in the regional and institutional committee meetings to involve the Health Services personnel (Doctors and senior paramedical staff) in the training of undergraduates.	Co-ordinator, Principal & Dist. Medical Officer.
	2. Intimate the decision to the concerned officers.	Dist. Medical Officer
	3. Organise I day training to the Health Services staff.	Principal, DMO, Co-ordinator & Com. Medicine Dept.
	4. Fix roles and responsibilites to each person in the training of undergraduates.	DMO, Co-ordinator & Com. Medicine Dept.
	5. Prepare a training calendar.	Co-ordinator, Dept. of Com. Medicine

GUIDELINE No. VII

The entire period of internship training will be spent in suitably upgraded Dist. Hospital, Taluk hospital P. H. Centres. Depending upon the availability of facilities at Dist hospitals, the no. of interns posted at Medical College hospital will be reduced.	1. Change the curriculum of M B B S Course	Principal, Co-ordinator and Heads of Departments. (IMC has already recommended the same in 1981)
	2. Decide on the duration of posting of interns in Dist, Taluk hospitals and P. H. Cs and in Medical Colleges.	do.
	3 Formulate posting orders of each batch and implement the same.	Co-ordinator, Dept. of Com. Medicine & Medical Officers of Concerned institutions.
	4 Chalk out a plan of effective supervision guidance system and execute the same.	do.
	5. Evaluate periodically.	Dept. of Com. Medicine, doctors of concerned institutions.

GUIDELINE No. VIII	ACTIVITIES TO BE CARRIED OUT	RESPONSIBILITY
The Medical College staff will extend their services to the fullest extent in the training of paramedical and other anciliary health staff, required in the development of a threetier system of delivery of health care	1. Take classes for paramedical trainees as and when requested.	All faculty members
	2. To conduct short training courses for para–Medical and other ancilliary health staff of Medical College, Dist. Hospital, Taluk Hospital and P. H. Cs., in a phased manner.	Co–ordinator, Dept. of Com. Medicine, Medical Officers of concerned institutions.
GUIDELINE No. IX		
It is essential to collect the baseline data about the health status of the community concerned so that in future the impact of the entry of the Medical College in the health care delivery system could be evaluated periodically. The information collected will be in the following areas.	1. Prepare a schedule to collect baseline data specially for the suggested areas.	Co–ordinator & Dept. of Com. Medicine., Heads of Departments.
	2. Collect data required for the 3 primary health centres selected.	P. H. C. field staff, undergraduates and interns and Dept. of Com. Medicine.
	3. Analyse the data and prepare a repot.	Dept. of Com. Medicine & Post–partum programme.
Demographic data, Family Planning, Maternal & Child Health Nutritional status, Communicable diseases, especially TB, Leprosy, VD, Parasitic infestation & immunisation.		

GUIDELINE No.X	ACTIVITIES TO BE CARRIEC OUT	RESPONSIBILITY
Each Medical College will evolve a scheme for health care delivery system in depth for a dopulation of about 30,000. The experimental models will be utilised in extending indepth services for the rest or the area in future.	1. Decide on the area and population for the indepth health care delivery system.	Institutional Committee, Co–ordinator and Dept. of Com· Medicine.
	2. Decide on the additional inputs or experiments to be conducted in the new area.	do.
	3. Implement the suggested schemes.	All departments of Medical College and all staff of the P.H C. in which the area is situated
	4. Evaluate the implemented special schemes periodically, annually if possible.	Institutional and Regional Committee and Com. Medicine Department.

GUIDELINE No. XI		
At present the research that is being carried out is individual based and of limited application to the needs of the community. Therefore, the Medical Colleges will formulate research schemes which will have practical application to the basic needs of the community.	1. List out research problems associated with the health needs of the community.	Co-ordinator, Dept. of Com. Medicine, D.M.O.
	2 Involve all departments in the Medical College, District hospitals, Taluk hospitals and P. H Cs. in the conduct of research schemes selected.	Principal & D.M.O.
	3. Find out necessary resources.	Principal, DMO & Co–ordinator.
	4. Conduct studies.	All Departments
	5. Utilise study results for future improvements.	Co–ordinator, Dept. of Com. Medicine and Institutional Committe and D.M O.

GUIDELINE No.XII	ACTIVITIES TO BE CARRIED OUT	RESPONSIBILITY
In order to motivate the students in their wholehearted participation in the rural posting a scheme of periodical assessment of the studies will be built in the programme. At the University level, the exam. will so structured that a stress will be laid on the assessment of knowledge gained by the studies during the posting.	1. Formulate a scheme for assessing the performance of students and interns in the rural posting and the consequent acquisition of competencies, skill development and attitudinal changes.	Co-ordinator, Dept. of Com. Medicine and Head of Departments.
	2. Implement the prepared scheme in the appropriate examination.	All faculty members.
	3 Periodic evaluation and feedback.	All faculty members and Institutional Committee
GUIDELINE No. XIII		
To bring about the far reaching changes in the present system of medical education/health care delivery system, an effective administrative machinery will be evolved for co-ordinated effects and for providing official support for the field programmes. Constitution of the committees at the institutional, regional and state level should be done with the composition broadly as follows:	1. Constitute state level committee	State Government (already done) GO (MS) 281/79/HD dt. 14-12-79 of Health (P) Dept.
	2. Constitute Regional Committee	Dist. Collector &Co-ordinator (already done)
	3. Constitute Institutional Committee	Principal, Co-ordinator (already done)
	4 Create additional posts as recommended by the Co-ordinators, Principals, DMEs and Secretaries of Health at the National Workshop on 'ROME' Scheme at New Delhi during 1985. Viz.	State Government D.M.E. Principal Co-ordinator

CUIDELINE No. XIII contd.	ACTIVITIES TO BE CARRIED OUT	RESPONSIBILITY
(a) Institutional level Committees has to be constituted by the Dean/Principal and will preferably include senior staff members whose involvement is necessary for the success of the programme. It may also invite relative Health Dept. officials to attend the meeting.	a. 3 Asst. Professors in the Dept. of Com. Medicine	
	b. 1 Field Co—ordinator in the rank of Assoc. Professor in Com. Medicine.	
	c. 1 Asst. Professor in Medico Sociology in Com. Medicine.	
(b) At each Medical College level there will be Co-ordination Committees with Dist. Collector as the Chairman, Principal, Medical College and D. M. O. as members and Prof. of Com. Medicine as Member Secretary.	5. Create posts of Cook & Caretaker—cum—Food supplier for providing stay facilities for students and interns in P. H. Cs—in the 'ROME' Scheme hostel building.	State Government D. M. E. Principal, Co-ordinator
	6. Get 2 more mini buses as suggested in the final recommendation of the National Workshop on 'ROME' Scheme held at New Delhi.	do.
	7. Get more central assistance as recommended by the above National Workshop.	do.
(c) The State level Committee consist of:		
1. Minister of Public Health	(Chairman)	
2. Minister of Harijan Welfare	(Vice Chairman)	
3. Secretary, Health	(Member)	
4. Secretary, Development	"	
5. Director of Health Services	"	
& 6. Director of Medical Education	(Member Secretary)	

MONITORING & EVALUATION

At present monitoring and evaluation of Re-orientation of Medical Education is done through the analysis and interpretation of quarterly reports being sent by the participating Medical Colleges.

While it covers major areas like construction activities, appointment of staff, formation of committees, baseline data collection, mobile clinics, expenditure on staff, equipments and drugs, it does not try to measure the changes brought about in the undergraduate and internship level in the community aspects of health care as recommended by the Medical Council of India on Graduate Medical Education in March, 1981.

Since the salient features of the 'ROME' Scheme have been embodied in the recommendations of the Medical Council of India and adequately recognised in the prescribed curriculum throughout the three phases of the training and internship period, quarterly report also should contain columns to collect information on the stage of implementation of the Indian Medical Council recommendations in the three phases and internship period. Similarly provision should be made to measure the development of relevant comptencies, skills and attitudinal changes in the undergraduates, interns and staff members. Hence the existing quarterly report proforma may be recasted to incorporate relevant additional points.

APPENDIX I

Copy of G. O. M S. No. 281/79/HD dt. 14th Dec. 1979 from Health (P) Dept., Trivandrum.

Annual Plan 1979-80—centrally sponsored scheme–reorientation of medical education—implementation in 4 Medical Colleges in the State—sanctioned— orders – issued—

Read:
1. Lr. No. 11011/2/76—ME (Policy) dt. 15–7–77 from Govt. of India, Ministry of Health & F. W., New Delhi.
2. Lr. No. 11011/2/79 ME (P) dt. 21–5–79 from Govt. of India, Ministry of H & F. W., New Delhi.
3. Lr. No. 11011/2/76 ME (P) Vo; 11 dt. 30-8-79 from Govt. of India, Ministry of H & F. W., New Delhi.
4. D. O. Lr. No. 10652/P3/78/HD dt. 19–9–79 from Special Secy. (Health) to the Jt. Secy, Ministry of Health & F. W., New Delhi.
5. Lr. No. B2—4065/78 dt. 12–9–79 from the Principal Medical College, Trivandrum.
6. Lr. No. U. 11011/71/78/ME (P) dt. 27-9-79 from Govt. of India, Ministry of H & F. W., New Delhi.

ORDER

In the letter read as Ist paper above, Govt. of India have forwarded Re-orientation of medical education to be implemented through the medical colleges as a centrally sponsord scheme. The main object of the scheme is to give necessary rural bias and community orientation to medical education which is at present essentially urban and hospital oriented in outlook. According to the scheme suggested by the Govt. of India' 3 P. H. Cs should be attached to each Medical College for improved medical relief and health care to the community. The students as well as the instructors of the Medical Colleges will be required to be stationed in batches in P. H. Cs to have a first hand knowledge of community medicine and preventive health care.

2. The programme of re–orientation of medical education as envisaged by Govt. of India and the pattern of central assistance are given in Appendix X

3. The Government have examined the proposal of the Govt. of India in consultation with the Principals of the Medical Colleges and the Director of Health Services. As the implementation of the scheme with central assistance will be beneficial in extending the health care to rural areas Government have decided to implement the scheme in the State.

4 Accordingly the following orders are issued in the matter:–

I. Sanction is accorded for the implementation of the scheme of re–orientation of medical education in 4 Medical College of this state through the P. H. Centres, shown in Appendix II.

II Each Medical College will be allotted 3Mobile Clinics, each costing over Rs. 4/– lakhs, and well equipped and containing a mini operation theatre with all modern equipments and to run rural medical camps. The vehicles will be delivered to the Medical Colleges on receipt of the same from the Govt. of India. The description of the vehicle is in appendix III.

III. The scheme will be implemented in accordance with the guide lines contained in App. I.

IV. Sanction is accorded for the creation of the following temporary posts till the end of Feb. 1980.

1. Medical College, Trivandrum.

X X X X

2. Medical College, Kottayam:

Driver (310–490)		4
Mechanic	"	1

V. Sanction is also accorded for the constitution of the following committees for implementation of the scheme:

1. STATE LEVEL CO-ORDINATION COMMITTEE:

1.	Minister (Public Health)	Chairman
2.	Minister (Harijan Welfare)	Vice Chairman
3.	Secretary (Health)	Member
4.	Secretary (Development)	"
5.	Director of Health Services	Member Secretary

Till the Ministry is formed, the officers attending to the duties of the Ministers concerned will be in the Committee.

II. REGIONAL CO-ORDINATION COMMITTEE AT EACH MEDICAL COLLEGE:

1.	District Collector where the Medical College is situated:	Chairman
2.	Principal of the Medical College	Member
3.	Dist. Medical Officer	"
4.	Prof. in General Medicine of the concerned M.C	Member Secy.

5. The P. H. Centres in Appendix II to this order will be under the administrative control of the Director of Health Services and the technical control of the Principals of the Medical Colleges concerned in so far as the implementation of this scheme is concerned.

6. The Principals of the Medical Colleges will forward to Govt. proposal for the construction of buildings immediately.

7. In the letters read as 2nd and 6th papers above the Government of India have released non-recurring grants-in-aid for the scheme of re-orientation of medical education as follows:

1978—79 for 2 Medical Colleges	Rs. 9.58 lakhs
1979—80 for the remaining	9.58 lakhs
2 Medical Colleges.	
Total:	19.16 lakhs

8. The expenditure for implementation of the scheme will be debited to '280 Medical-A Allopathy (c) Education-27-Re-orientation of Medical Education (centrally sponsored). Excess expenditure if any, is authorised to be incurred under para 95 (3) of the Budget Manual, to be regularised later on by reappropriation or supplementary demand. The amount to be additionally provided under this head will be intimated by the Principals concerned.

9. The Principals of the Medical Colleges will forward quarterly reports in respect of the programme of implementation of the scheme to Government regularly and promptly.

(By order of the Governor)
J. Lalithambika
Secy. to Govt.

/true copy/
Sd/-
for D. F. W. M. O. in charge.

APPENDIX II

Programme of Re-orientation of Medical Education and Central Pattern of Assistance.

The Ministry of Health & Family Planning appointed a top level committee called the Group on Medical Education and support manpower and the report of the said group were duly processed by a sub committee of this Ministry and a concrete plan of action was drawn up wich was adopted by the Third Joint Meeting of the Central councils of Health & F. P. in its resolution and were later on ratified by the conference of Deans and Principals of Medical Colleges in India.

In order to start the operation of implementing the programme concretised in the Plan of action by each State Govt./U.T. its is imperative that the following guidelines be kept in view by the State Govt. U.T. to achieve the specified objectives envisaged in the plan of action with scope for flexibility and modification suitable to the varying local conditions prevailing in each State/U. T. wherever considered necessary.

1. The Govt. Medical Colleges in the State will accept total responsibility of promotive, preventive and curative health care of at least 3 community development blocks in the Dist. were the medical college is situated, in the first instance. By adopting the programme, each Medical College in the State will extend total health care to the entire district in which the Medical College is located, in a phased manner over a period of 3-5 years.

2. Each Medical College will evolve with the active involvement of Dist. hospitals, Taluk hospitals, sub-divisional hospitals and P. H centres a well–knit referral service complex. To achieve this, a working group will be set up at the Medical Colleges or Civil hospitals under the chairmanship of the Principal/Dy. Director of the Region involving personnel from these institutions.

For the susccess of such a referral system, a continuous dislogue will be maintained between the Medical Colleges, Dist. hospitals, cottage hospitals and the civil dispensaries and P.H. Centres. To start with, a programme will be chalked out involving the centres which are nearer to the Medioal Colleges

The staff of the Medical College will be required to attend theDist. and Taluk Tahsil, sub–divisional hospitals by rotation for the purpose of improving the hospital services at the civil and taluk tahsil, subdivisional hospitals.

The Medical College will also extend co–operation in providing the peripheral units mainly with expertise and assistance in laboratory services, radiology services, clinical services, imqlementation of national programmes, control of communicable diseases, nutrition, maternal and child health services, and family planning. With this aim in view, the resources of Medical Colleges, Dist hospital and Taluk/Tahsil sub divisional hospital and the P. H. Centres will be pooled together in respect of manpower equipment contingent grants etc. to evolve a well–knit referral system

3. For the proper training of the undergraduate students in the rural health care programme, it is necessary that a balance is struck between the training he/she received in the Medical College, Dist. hospital and P. H Cs. This programme will be implemented in phases so that the student has opportunity to spend part of his training time in Dist. and Taluk/Tahsil, sub–divisional hospitals and P. H. centres.

4. The training of the undergraduate medical students will be recast within the integrated comprehensive health services complex making provision in the time table for the posting in the rural areas where they will be actively involved in the services extended by the P.H. Centres and subcentres. During the undergraduate period of training at least 8 weeks annual posting in rural areas will be provided in time table.

Each Medical College will evolve a detailed training programme for the undergraduate medical students as well as interns which they will carry out during their rural postings.

5. For the successful implementation of the total health care and improved training programme for the undergraduate students. It is imperative that entire faculty members, clinical non—clinical and paraclinical are involved in this programme. The staff members from the entire faculty will be posted at P H Cs. and sub centres by rotation for sufficienty long periods where they will be responsible for guiding the training of undergraduate students as well as interns and will supervise the development and implementation of the active heath care delivery programme. It will also be necessary to organise a reorientation programme for faculty members and health term personnel at each medical college.

6. The services of Dist. Health personnel, doctors working in Dist. hospital, taluk/Tahsil, subdivisional hospitals civil dispensaries and P.HCs will be utilised for organising the undergraduate training programme. They will be given appropriate teching status in the Medical College concerned oommensurate with their qualifications and field experience.

7. The entire period of internship training will be spent in suitably upgraded district hospitals, taluk/tahsil/tensil, sub divisional hospitals and PHCs. Depending upon the availability of facilities at the Dist. hospitals, the no. of interns posted at the Medical College hospitals will be reduced.

8. The Medical College staff will extend their services to be fullest extentin the training of paramedical and other ancilliary health staff, required in the development of a threetier system of delivery of health care.

9. It is essential to collect the base line data about the health status of community concerned so that in future the impact of the Medical College iu the health care delivery system could be evaluated periodically. The information will be collected in the followlng areas:

I. Demographic data

Ii. Family Planning

III. Maternal and child health

IV. Nutritional status

V. Communicable diseases especially tuberculosis, leprosy and venereal diseases.

VI. Parasitic infestations

VII. Immunisation.

10. Each Medical College will evolve a scheme for health care delivery system in depth for a population of about 30 000. The experience gained from those experi— imental models will be utilised in extending indepth services for the rest of the area in future.

11. At present the research that is being carried out in Medical Colleges is individual based and of limited application to the needs of the community. Therefore, the Medical Colleges will formulate research schemes which will have the practical application to the basic health needs of the ccmmunity. The involvement of the Medi. cal Colleges in the rural health care delivery system will be conducive in undertaking research projects which will be of significant value to the community. The help of the research finding organisations like Indian Council of Medical Research and approval international agencies will be obtained as far as possible in carrying out these research projects.

12. In order to motivate the students in their whole hearted participatoin the in rural posting, scheme of periodical assessment of the studies will be built in the programme. At the University level, the examinations will be so structured that stress will be laid on the assessment of knowledge gained by the students during the rural posting.

13. To bring about the far reaching changes in the present system of medical education/health care delivery system, an effective administrative machinery will be evolved for co–ordinated efforts and for providing official support for the field programme. At present the technical supervision or the working of the PHCs is done by the Director–ate of Health Services through Director Jr. Director–Dy. Director DHS. Under the new set up it is envisaged that this will be done through Directorate of Medical Education and Research/D.H.S. Dean–DHS. Necessary administrative orders in this regard will have to be issued by the Govt. The following commissions will also be constituted with the composition broadly on the following lines.

State Level co–ordination committee:

1. Minister of Public Health & rural development	Chairman
II. Minister of State for Pub. Health	Vice Chairman
III. do. Rural Development	do.
IV. Secretary, Public Health Dept.	Member
V. do. Rural Development	"
VI. D. H. S.	"
VII. D. M. E. & Research	Secretary.

1. The D. H. S. shall be the Member Secretary where there is no separate post of D. M. E. & Research in existence.

2. At each Medical College level, there will be Regional Co–ordination committee.

a. Chief Executive Officer Z. P.	Chairman
b. Dean of the Med. College	Member
c. Dist. Health Officer	do.
d. Prof. of Com. Medicine	Member Secy.

f. There should be an institutional committee constituted by the Dean with appropriate members. Advisably the College level committee should consist of all senior staff members whose involvement is necessary for the success of the programme. It may also invite Medical Officers and other staff of the PHCs when required. The Regionnl Co-ordinative committees and institutional committees should submit periodical reports at least once a month. These reports should be submitted to the D. M. E. and Research who will consolidate and put up before the state level co–ordination committee.

The pattern of financial assistance that the Central Govt. is required to provide to the State Govts/U. T. administrations and certain autonomous Medical Institutions. namely AIIMS, New Delhi, PGIMER, Chandigarh and Jawaharlal Institute, Pondicherry will be broadly on the following lines;

CENTRAL GRANT IN AID TO STATES FOR THE ORIENTATION OF MEDICAL EDUCATION

Break-up of assistance of Rs 4.79 lakhs per Medical College.

		Rs. lakhs
A.	Non–recurring:	
	I. Dormitory type residential quarter for lady students	1.75
	II. Seminar room, lecture–cum–consultation room	0.25
	III. Surgical equipment, instrument, etc.	0.60
	IV. Suitable addition or alterations to PHC operation theatre, etc.	0.40
	V. Furniture, books etc.	0.50
		3.50
B.	Recurring:	
	I. Additions to faculty	0.40
	II. Steno–typist	0.14
	III. Driver, mechanic for each vehicle	0.30
	IV. Drugs	0.45
		1.29

A + B = 4.79 lakhs

APPENDIX III

No. U. 11001 1/10/ 80-ME (P)
Government of India
Ministry of Health & Family Welfare
(Department of Health)

New Delhi, dtd. 23-12-1981.

To

1. The Health Secretaries of States/UT (having Medical College) as per list attached.
2. The Director, AIIMS, New Delhi.
3. The Registrar, Banaras Hindu University, Varanasi.
4. " Aligarh Muslim University, Aligarh.
5. The Secretary, Kasturba Health Society, Wardha.

Sub Centrally sponsored scheme —Reorientation of Medical Education scheme–revised pattern of central assistance for implementation of the scheme–regarding–

Sir,

As you are aware, the Reorientation of Medical Education Scheme was launched in 1977 as a Centrally sponsored scheme with the objective of involving the Medical Colleges in the direct delivery of Health care service in the rural and semi-urban areas and thus securing the reorientation of the teaching staff and the students, establishing a positive bias towards community services. To facilitate the implementation of the scheme a set of guidelines had been circulated to the States and Union Territories vide this Ministry's letter No. U. 11011/2/76–ME (P) dtd. the 15th July, 1977. As per the existing pattern of Central Assistance, communicated vide this Ministry's letter No. U. 11011/2/76–ME (Policy) dtd the 15th April, 1978, each Medical College is eligible for one-time, non-recurring grant–in–aid of Rs. 4.79 lakhs for covering 3 Development blocks under Phase I of the Scheme.

The implementation of the scheme has recently been reviewed in depth and it has been decided to consolidate the Ist phase of the programme, with additional financial inputs for the establishment of the infrastructural facilities, over and above these provided under the existing pattern of central assistance, before embarking upon the originally envisaged extension of the programme, under Phase—II.

The pattern of assistance under Phase I of the scheme has accordingly been revised. The revised pattern provides for additional financial assistance of Rs. 9 60 lakes per college i. e. 3.20 lakhs per P. H. Centre for covering additional structure costs, Rs.75,000/– for procuring mini bus for transporting students and members of the faculty and Rs. 90,000/–for the construction of 3 garages, one for each of 3 Mobile Clinics. In all additional financial assistance of Rs. 11.25 lakhs per Medical College is now available for the purpose of consolidating the gains achieved under Phase I of he scheme. The suitable location of the garages may be determined by the concerned Medical Colleges keeping in view the operational areas and distances involved and the place at which the Mobile Clinics would require to be stationed. The detailed breakup of the revised pattern of central assistance is given in appendix–I.

3. Financial assistance for the procurement of a mini bus, per college and for the construction of garages under the revised pattern of assistance is proposed to be released in the current financial year 1981—82, subject to the availability of funds. Additional assistance for the construction works shall be phased out, year–wise, depending upon the availability of funds and the progress actually achieved by the Medical Colleges under Phase I of the scheme.

4. The reorientation of medical education is a 50-50 centrally sponsored scheme The onus of implementation of the scheme rests with the concerned State Govts. and UTs. All recurring and non–recurring expenditure over and above the Central grant-in-aid for the implementation of the scheme is the liability of the concerned States/UTs. The details of the approximate expenditure to be borne by the State Govts./UTs per annum or college, during the VI Five year Plan, are given in Appendix II.

5. The salient features of the scheme have been embodied in the recommendations of the Medical Council of India on Under–graduate Medical Curriculum which makes it mandatory for each Medical College to adhere to them. The implementation of the scheme, therefore, becomes statutorily necessary as, otherwise, the concerned medical colleges will stand the risk of derecognition by the Medical Council of India. The Govt. of India, therefore, seeks the most active cooperation of the State Govts./UTs in the effective implementation of the scheme.

Additional Central Assistance under the revised pattern for Phase I of the Reorientation of Medical Education scheme.

Item	Offered under the existing pattern	Prepared revised pattern of assistance, per PHC	Additional Assistance as per the revised pattern per PHC
Construction works:	Rs.	Rs.	Rs.
Dormitory type Residential accommodation for students at P. H. Cs (5) faculty members 10 male students & 5 female students.	58,000	3,00,000	3,42,000
Seminar room-cum-lecture room	8,000	50,000	42,000
Additional and alterations to PHCs/operation theatre etc.	14,000	50,000	36,000
	80,000	4,00,000	3,20,000
Procurement of Mini Bus for each college	nil	75,000	75,000
Contruction of a garage per college for Mobile Clinics	nil	30,000	90,000

Details of the expenditure to be borne by the State Governments/UTs per annum per college during the Sixth Five Year Plan

Rs. in lakhs

1. Essential item of recurring expenditure	Expenditure per college per annum	
1. Additions to faculty	0.40	
2. Steno–typist	0.14	
3. Driver –Mechanic for each	0.30	
4. Additional drugs	0.45	
5. Driver for Mini bus	0.07	
6. P.O.L. for 4 vehicles (3 Mobile clinics & I Mini bus)	1.00	2.50
7. Contingencies (like office expenses, mess facilities for students, nursing facilities of the O.T. in the Mobile Clinics etc.	0.14	

APPENDIX IV

EXTRACTS OF THE RELEVANT RECOMMENDATION OF MEDICAL COUNCIL OF INDIA ON GRADUATE MEDICAL EDUCATION

(Adopted by the MCI at its meeting held on 19.3. 1981)

PREAMBLE

The Council recognises the importance of the community aspects of health care and of rural health care services. This aspect of the training of undergraduates has been adequately recognised in the prescribed curriculum. Its importance has been systematically upgraded over the past years and adequate exposure to such experiences has been provided throughout all the three phases of training. This has been further emphasised and intensified by providing on the job instruction and training during the internship period. The aim of the period of rural training during internship is to enable the fresh graduates to function efficiently under such settings.

2. Graduate medical education per se cannot be tailored to service situation for which in-service training is essential. The educational process should enable the graduate to adapt himself to different service situations on the basis of actual experience and in-service training. However, the educational experience has been duly modified to make it health oriented instead of disease oriented.

IV. MEDICAL CURRICULUM

3. The importance of social factors in relation to the problem of haalth and diseases should receive proper emphasis throughout the course and to achieve this purpose, the educational process should be more community based than hospital based.

The teaching of health education should form a part and parcel of all the subjects during the whole graduate course.

4. Throughout the meeical course, it is desirable that one hour a week should be assigned for interdepartmental teaching in which teachers from all departments of the college will participate by rotation so that during the pre-clinical period, teachers from the clinical departments will spend one hour a week with the pre-clinical students and other departments will spend one hour a week with the clinical students. In these sessions the main emphasis should be on the applied aspects of the subject concerned including History of Medicine with a view to bring about integration of teaching between the departments. For this purpose an inventory of suitable subjects should be prepared from year to year.

5. The importance of population control and family planning should be emphasised throughout the period of training and the importance of population control for health and development duly emphasised.

vi. PHASE I (PRE–CLINICAL SUBJECTS)

6. Three remaining months of the pre–clinical period are to be devoted to the introduction of clinical orientation of students which shall consist of the following:–

(a) History of Medicine

(b) Role of nutrition in health and diseases.

(c) Health economics.

(d) Introduction to Community Medicine, including–

i) principles of sociology including demography, population dynamics, social factors related to health and diseases, urban and rural societies, impact of urbanisation on health and diseases, community behaviour and ecology.

ii) Elements of normal pyschology and social psychology.

iii) The students shall also be introduced to the principles of practice of medicine including visits to the hospital for familiarisation with elementary nursing practices, practices of sterilisation, injection and dressing techniques, necessity for record keeping, art of communication with patients including history taking medico–social work and immunisation against diseases and health check up.

Note: (1) Teaching of community medicine, should be both theoritical as well as practical. The practical aspects of the training programme should include visits to the health establishments and to the community where health intervention programmes are in operation.

(2) In order to inculcate in the mind of the students the basic concepts of community medicine to be introduced in this phase of training, it is suggested that the detailed curriculum drawn should include at least 30 hours of lectures, demonstrations, seminars etc., together with at least 15 field visits spread over 18 months in various aspects of community medicine.

COMMUNITY MEDICINE

7. As far as the teaching of the Community Medicine is concerned, health/medical officers in the service of the State who have adequate field experience should be utilised for teaching of community medicine giving them appropriate status, if necessary. Likewise medical college teachers should by rotation be posted in field practice areas with batches of students to introduce community orientation in training programmes.

8. Community Medicine Posting: The students shall either be posted in the Health Training Centre unit or in one of the Primary Health Centres attached to a Medical College or Rural Hospital or such posting shall be given by visits to the field practice area according to the facilities available and the student shall participate during this period in various activities of preventive and promotional health programmes at the centre. Where sufficient facilities for taking the students to rural areas are not yet developed urban field practising area (slums) may be used for this purpose in the initial stages. Such postings shall be arranged during the IInd and IIIrd phases. The details of this posting should be worked out by the institution concerned. Students are to be inducted to National Health Programmes during these postings and given an overall comprehensive view of the nature and objectives of these programmes.

N.B.(1) For developing community posting facilities each Medical College should be in total charge of three Primary Health Centres where the teachers from all disciplines in the Medical College should be posted by rotation. The number of Primary Health Centres should gradually be increased so as to cover the entire district.

(2) It is necessary to pool the resources of the medical colleges, district and sub–divisional level hospitals and primary health centres in the referral services complex with required augmentation in respect of transportation, equipment, drugs etc. and for providing residential accommodation at district, sub–divisional hospitals and primary health centres,

INTERNSHIP

9. The Compulsory Rotating Intemship for 12 months should be done in teaching and non–teaching approved hospitals like District Hospitals and Rural Health Training Centre/Upgraded Primary Health Centres attached to the teaching institutions. Satisfactory collaboration must exist between such hospitals / rural centres and the medical colleges. The Compulsory Rotating internship shall include training in Medicine, Surgery and obstetries and Gynaecology and in Community Health work at Rural Health Training Centre of Upgraded Primary Health Centres. The posting in Community Health Work should be for a minimum period of six months. The students should be placed for inservice training in Family Planning clinics for a period of one month. In the task oriented training the responsibility of the interns as participants in the institutional and domiciliary service programme should receive due attention. For this purpose, all necessary inputs should be provided, like accommodation, transport, adequate clinical fecilities etc.

Provided that where an internee is posted to District / Sub–Divisional Hospital for training, there should be a Committee consisting of representative of the College/ University, the State Government and the District administration, who shall regulate the training of such trainee.

Provided also that for such trainee a certificate of satisfactory completion of training should be obtained from the relevant administrative authorities which shall be countersigned by the Principal a / Dean of College.

Adjustment to enable a candidate to obtain training in elective clinical subjects may be made.

10. The Intern shall maintain a record of work which is to be verified and certified by the medical officer under whom he works. Apart from scrutiny of the record of work, assessment and evaluation of training may be undertaken by an objective approach using situation tests in knowledge, skills and attitude during and at the end of the training. Based on the record of work and date of the evaluation, the Dean / Principa shall issue certificate of satisfactory completion of training, following which the University shall award the M.B.B.S. degree or declare him eligibe for it.

COMMUNITY HEALTH – RURAL POSTING

Rural experience should train the doctor to become the leader of the health team, it should involve –

(a) Supervisory Responsibility – Administrative — Technical

(b) Community based health activities, Organisation implementation.

Control of communicable diseases (special emphasis on Tuberculosis, Leprosy and V. D.)

Implmeentation of Public Health Programme.

Applied Nutrition.

Maternity and Child Health, Family Planning, School Health and Nutrition Health Education etc.

TEACHERS TRAINING

12. In order to effectively implement the programme of producing qualified medical graduates so as to enable them to function effectively under the prevailing social economic condition of our country, it is essential that workshops are held for teachers of medical colleges in different parts of the country at a State and National level to orient them to :–

(1) Problems of community health and delivery of health care.

(2) Methods of teaching and examination in relation to the objectives of post graduate education.

CURRICULUM ON SOCIAL AND PREVENTIVE MEDICINE FOR GRADUATE TEACHING

13. The objective of the internship should be clearly defined and that a proper training programme be oriented for this period. objectives. and the methods by which the internship could be made into a much more satisfying and fruitful experience than at present have been laid down. This is one of the weaklinks of the teaching programme and there is an urgent need for sharpening and for planning in this phase of education.

CURRICULUM

14. The present educational system requires those students intending to undertake medical studies to choose the science group of subjects. In order to prepare the student for professional education ard to foster in him the social concepts which are essential to the professional doctors as a citizen and as practising physician in the community, the element of humanities which has been cmitted, should be added in the pre-clinical years. Hence it is imperative that the social concepts of medicine should be incorporated and emphasised alongwith other disciplines.

15. Aminimum of 30 hours for didactic teaching, practicals, demonstrations and 15 field visits each for full day for understanding of rural health problems be underthken during the first three terms.

i) Personal Hygiene

ii) Bio-statistics and Vital Statistics

iii) Human Ecology

iv) Elementary Psychology

v) Elementary social Science

vi) Normal Growth and Development

vii) Nutrition and dietetics.

A number of these items could be undertaken in collaboration with the departments of Physiology and Bio-chemistry and should form an integral part of their teaching.

16. The following subjects should be included in the teaching programme during the first three terms.

(a) Introduction of Community Medicine

(b) Principles of sociology including demography, population dynamics and elements of biostatistics, social factor related to health and diseases, urban and rural societies urbanised impact on health and diseases, community behaviour and ecology.

(c) Elements of normal psychology and social psychology, teaching of community medicine should be both theoretical as well as practical. The practical aspects of the training programme should include visits to the health establishement and to the community where health intervention programme are in operation.

COMMUNITY MEDICINE

Phase I - Preclinical Period : first 3 academic terms.

17. The entire class is divided into 2 batches. Once a fortnight by rotation one batch to work in the hospital for practical experience in the following area:

1) Nursing including, bed making

2) Practice of sterilisation.

3) Techniques of infection and dressing.

4) Management of hospital including clean linen.

5) Bedside manner and medicine ethics.

6) Art of communication, History taking, winning the confidence of the patient

7) Record keeping - completeness and reliability.

8) Patient psychology – understanding the patient's perception of his problem.

9) Medico-social work.

10) Principles of health education—Doctor's role.

The other Batch, by rotation goes for group discussion, seminar and lecture/ demonstration in the following

1) Demoraphy and population dynamics

2) Way of life in urban and rural societies.

3) Process of urbanisation and its impact

4) Behaviour of community.

5) Inter-dependence and inter-relation between man and his environment including Nutrition.

6) Health monitoring, including nutrition. Time allotted 6 hrs/month for 10 months: 60 hours.

FIELD VISITS:

Once a fortnight all the students shall make field visits and for this purpose, the class may be divided into batches of 20 students. Detailed programme may be drawn up by each college forthis purpose.

The following aspects will be covered during these visits:

(1) Factor determining healh and disease including environmental influences

(2) Applied sociology – importance of oommunity participation.

(3) Limited resources – Necessity of maximisation of utilization.

(4) Impact of nutrition on Health and Disease.

FIELD POSTING FOR COMMUNITY HEALTH DURING IIND CLINICAL YEAR:

The students should be posted in small batches for residential posting of one month at selected approvd Primary Health Centre/Rural Training Centres during the fourth clinical term (II clinical year).

During this period they should participate in the promotive, preventive and curative activities of the health centre so as to get an insight into the socio-economical, cultural and psychological factors influencing the pattern of health and disease in the community as a whole.

The family should be the unit of study rather than an individual patient so that the impact of health problem on the family can be observed and understood by the students.

They should a-ctively participate in the implementation of the national health programmes, family planning and M. C. H. activities and health education.

They should taken an opportunity to investigate epidemic outbreaks whenever such a situation arises.

This training will also be under the supervision of a teacher from the medical college faculty who will be given residential posting at the rural centre for not less than two months.

The teacher should attempt to demonstrate the practice of comprehensive health care which can be practised at the village and the level at which referral to a better facility is essential. Various officers of health services should also be utilised for this part of tranining.

Teachers from the entire faculty of medical college should be given adequate orientation and then posted in turn to rural centres for the training of graduates in community health.

18. COMPULSORY ROTATING INTERNSHIP – RURAL TRAINING

It is essential to outline the objectives that are to be achieved during the 6 months rural stay during internship period. An outline of the objectives to be achieved is suggested.

(a) Administrative aspects.

(b) Preventive aspects.

(c) Clinical aspects.

(A) ADMINISTRATIVE ASPECTS

1. Under administrative aspects, rural internship should serve to orient the student in the political structure and administration of a rural area, and in the actual working of those organisations concerned with local self government namely, zilla parishads, the panchayat samities and other fact of community development work.

2. It should serve to orient the intern with the concept of team work with paramedical health workers, namely the health visitor, the vaccinator, the sanitary inspector, the social scientist and the health educator, especially in connection with national health programme.

3. It should orient the intern in social dynamics of community. This should include the dynamic leadership, the motivation of a community and the various important fact of influencing leaders in the promotion of health programmes. This is an integral part of the application of health education principles in the promotion of development work.

4. It should serve to orient the doctors on the administrative aspects of various national health programmes which are an integral part of work at the primary health centres. These should piimarily be such programmes :—

   (a) the malaria eradication programme.

   (b) small pox eradication programme.

(c) tuberculosis control

(d) Family Planning

(e) certain specific communicable diseases, such as filaria, leprosy, trachoma V.D. etc.

5. It should serve to put the health programme in the perspective of the overall national development programmes, namely agriculture, education, social welfare etc.

(B) PREVENTIVE ASPECTS

1. It should serve to orient the intern in the orgunisation and management of a comprehensive health service for a community. This programme should invariably include the environment of the community.

2. It should serve to orient the intem in the role of individual members of the health team and of important leaders in a community.

3. It should serve to orisnt the doctor on the keeping of adequate statistical records and of the interpretation of health indices.

4. It would serve to orient the doctor towards the effective utilization of all resources in the community for promotion of health programmes.

5. It would serve to indicate that illness is an episode in the total frame work of an individual health. The needs for adequate contact tracing and followup of sick patients atter therapeutic treatment should be demonstrated to the maximum in a rural community.

6. It should given an indication of the priority needs of various facts of health programmes, such as the importance of immunisation importance of school health programmes, importance of nutritional education, care of the pre-school child, etc.

7 The social effects of illness of an individual and family and the result of socio-economic factors in causing illness should be demonstrated.

8. The planning and evaluation of a community health service.

(C) CLINICAL ASPECTS

1. It should sharpen an individual's diagnostic capacity, so that he may be able to make use of his individual senses without dependence on expensive aids, such as laboratory, x-ray etc.

2. It should permit an individual taking responsibility for minor iliness and surgical complications.

3. It should serve to indicate his limitations and realization of when to call for consultative services or a referral.

The methods by which this could be achieved :

1. A planned programme in order that all students should have an opportunity to meet with village representatives and to participate in village meetings, especially those of the health committee. In order to effectively demonstrate the role of community leaders in a health programme, it should be the duty and responsibility of the staff of the rural field centre to from a health committee in every rural field training area.

2. The role of other officials in the village, namely the teacher, the village level worker, ect. should also be demonstrated and the students should be given an opportunity to meet with the block development officers and his staff, and to become familiar with the other development programmes in the village.

3. Every effort be made to ensure that the hostels and the houses of the staff of the health centre, as well as the surroundings of the centre itself should be such that minimum facilities, such as protected and safe water, latrine etc. are provided. Wherever possible, the students should be made to live in the village, but under hygienic conditions which are capable of reproduction by the villager.

4. The students should have an opportunity of visiting and being demonstrated the varlous national health programmes. For this purpose, the staff of the rural field training area should have liaison with the staff of the various national health programmes.

5. It should be ensured that the primary health centre is supplied with adequate vaccines and serve and modern drugs.

6. The administrative aspects of running a primary health centre should be demonstrated to the students and they may be allowed to make suggestions in such matters, as the purchase of drugs, the type of basic equipment, the cost of the diet, etc. and how the centre funds could best be utilised.

7. The students should have every oppotunity of working with the health centre staff and visiting the homes. The principles of health education and the approach to a community, and of an individual should also be effecrively demonstrated to them and the students be required to practise this under skilled supervision.

8. To effectively implement the above requirements, the staff of the field training area be adequate in number, be properly trained, and have the facilities to undertake the teaching and training that are required.
